Carroll County Digestive Disease Center
216 B Washington Heights Medical Center, Westminster, Maryland 21157 (Telephone) 410-857-5113

Patient Medical History Form

Please complete in blue or black ink, and bring this FORM, ALL INSURANCE CARDS, and REFERRAL (if needed) with you at the time of the procedure. Please do not use white-out on this form.

REMINDER: YOUR RIDE MUST REMAIN IN THE FACILITY DURING YOUR PROCEDURE.

Patient Name: _____
Have you had this or a similar procedure before? ☐Yes ☐No Date_____

List ALL surgical procedures and implanted devices (artificial joints, pacemaker, defibrillator, etc.) and year

_____

_____

_____

_____

_____

_____

Did you ever have a problem with anesthesia or sedation? ☐ Yes ☐ No Comment: _____

Do you have a history of post-operative nausea and vomiting? ☐ Yes ☐ No Motion Sickness? ☐ Yes ☐ No
Migraine headaches with nausea and vomiting? ☐ Yes ☐ No Do you smoke? ☐Yes ☐ No How much?
_____

Are you hearing impaired? ☐ Yes ☐ No Are you vision impaired? ☐ Yes ☐ No
Indicate any special religious, cultural, or language needs:
_____

Weight: _____ Could you be pregnant? ☐Yes ☐ No ☐ N/A

IF YOU HAD OR STILL HAVE ANY OF THE FOLLOWING PLEASE CHECK.

Bronchitis, chronic cough	☐	**Anemia**	☐	**Diabetes**	☐
Asthma	☐	**High blood pressure**	☐	**Low Blood Sugar**	☐
Pneumonia	☐	**Low blood pressure**	☐	**Thyroid trouble**	☐
Tuberculosis	☐	**Jaundice, hepatitis**	☐	**Kidney trouble**	☐
Emphysema	☐	**Liver problems**	☐	**Physical disabilities**	☐
Shortness of breath	☐	**Colon polyps**	☐	**Anxiety/Depression**	☐
Sleep Apnea	☐	**Colon cancer**	☐	**Osteoporosis**	☐
Rheumatic fever/MVP	☐	**Back pain or injury**	☐	**Gastritis/Ulcers/Acid Reflux**	☐
Chest pain or Angina	☐	**Seizures or epilepsy**	☐	**Cancer (location)_____**	☐
Heart attack(s)	☐	**Stroke**	☐	**Crohn's or Ulcerative colitis**	☐
Palpitations or irregular heart beats	☐	**Arthritis**	☐	**Nausea /vomiting**	☐
High Cholesterol	☐	**Alcoholism**	☐	**Rectal bleeding**	☐
HIV	☐				
OTHER					

Office Use Only